NEW Preferred Medication List (PML) INCLUDED!

Volume 6, Issue 1 *APRIL 2006*

COMPREHENSIVE MEDICAL & DENTAL PROGRAM

PROVIDER REVIEW

Department of Economic Security, Comprehensive Medical and Dental Program

CMDP Honors: Child Abuse Prevention Month - April 2006

The month of April is devoted to celebrating everything we can do to transform our community into a place that cares about - and actively supports – families and children. By ensuring that all parents in our community have access to quality childcare, affordable health services, parenting education resources and substance abuse and mental health programs, we make progress toward what the month stands for: **April is Child Abuse Prevention Month**.

Last year in Arizona there were 37,189 reported cases of child abuse affecting over 74,000 children. The majority of child abuse cases stem from situations and conditions that are entirely preventable in an engaged and supportive community. A community that cares about early childhood development, parent support and maternal mental health, for instance, is more likely to see families nurturing children who are born healthy and enter school ready to learn. Cities and towns that work to create good school systems and who come together to ensure that affordable housing is available in good, safe neighbourhoods are less likely to see stressed, isolated families who don't know where to turn.

Child Abuse Prevention Month is about connecting all of these dots so that the solutions to child abuse receive the attention the public craves. In a recent poll, 89% of Americans reported that child abuse was a "very important" moral issue to them. But it's not enough to care about the problem and address its consequences. We have to pay attention to the kinds of efforts that will prevent it from happening in the first place. So this April, learn more about what you and your community can do to support child abuse prevention. It's a shared responsibility and we're stronger together.

As a community it is our duty to be aware of the warning signs and act if necessary.
Examples of Abuse are:

- **Physical Abuse** - may be a result of punching, beating, kicking, biting, burning, shaking or otherwise physically harming a child. The parent or caretaker may not have intended to hurt the child; rather, the injury may have resulted from inappropriate discipline or physical punishment.
- **Child Neglect** - may be characterized by failure to provide for the child's basic physical, emotional and educational needs. Some examples are:
  - Children who appear to be malnourished.
  - Children inappropriately clothed for the weather.
  - Children have untreated illnesses or injuries.
  - Children living in a home which has health or safety hazards.
  - Children who are abandoned or not supervised appropriately and may be in danger due to lack of supervision.
- **Sexual Abuse** - may include rape, touching & fondling a child, or involving a child with pornography. Children who report sexual interaction with a parent or caretaker or who exhibit symptoms of sexual abuse.
- **Emotional Abuse**—may include acts or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional or mental disorders.
- **Shaken Infant Syndrome:** Vigorous shaking of a child under the age of two years old may cause severe brain injury or death.

Most child abuse occurs within the home involving a person or persons that the child knows. The best prevention for child abuse is community awareness and intervention. For additional information please contact CMDP at (602) 351-2245 or (800) 201-1795.

If you are working with children or families in any capacity, you *must* report suspected abuse or neglect to either law enforcement or Child Protective Services. (ARS 13-3620). SUSPECT ABUSE, REPORT IT. NOW!
1-888-SOS-CHILD (1-888-767-2445)

DEVELOPMENTAL DELAY AND SERVICE USE AMONG CHILDREN IN THE CHILD WELFARE SYSTEM

"This study shows that lack of service use for developmental delay is a significant problem in the child welfare population," state the authors of an article published in the February 2006 issue of the Archives of Pediatrics and Adolescent Medicine. The lives of children in the child welfare system are often characterized by exposure to numerous risk factors for developmental delay, including the direct effects of abuse and neglect, poverty, in utero drug exposure, parental substance abuse, and mental health disorders. Studies have estimated that between 13% and 62% of children entering foster care have developmental delay. However, accurate prevalence data and identification of factors that influence developmental status are lacking and rates of developmental service use among this high-risk population are rarely described in the literature. The objectives of the study described in this article were to estimate the prevalence of developmental delay and developmental service use among infants and children in the child welfare system and to identify factors that influence developmental delay and use of these services.

The authors found that

- Infants and children ages 0-2 represented 46% of the sample (n=1,998), children ages 3-5 represented 19% (n=834), and children ages 6-10 represented 35% (n=1,492). Forty-two percent were white and non-Hispanic, 33% were African American and non-Hispanic, 18% were Hispanic, and 7% were of other races and ethnicities.
- Twenty-four percent of the infants and children were developmentally delayed on at least one measure (cognitive development, language development, or adaptive skills).
- Infants ages 0-2 and children ages 3-5 had higher rates of developmental delay (37% and 33%, respectively), than children ages 6-10 (13%).
- Race, sex, income, type of child maltreatment and placement status did not have a significant impact on developmental scores or service use.
- Only 38% of the infants and children with developmental delay were using developmental services (20% of infants and children ages 0-2 with developmental delay, 38% of children ages 3-5 with developmental delay, and 57% of children ages 6-10 with developmental delay).

The authors conclude that "strategies for overcoming barriers to using early intervention services should be implemented."

Zimmer MH, Panko LM. 2006. Developmental status and service use among children in the child welfare system. Archives of Pediatrics and Adolescent Medicine 160 (2):183-186.

Taking Generic Form of Drug Boosts Regimen Adherence

TUESDAY, Feb. 14 (HealthDay News) -- Patients who take generic prescription drugs are more likely to adhere to their doctor's prescribed therapy plan than patients who take brand-name drugs, a new study finds. The findings are another reason why "generic drugs should be prescribed for patients beginning chronic therapy, as long as there are no specific clinical reasons why a branded drug may be more appropriate," researcher Dr. William Shrank, of Brigham and Women's Hospital and Harvard Medical School in Boston, said in a prepared statement.

The findings appear in the Feb. 13 issue of the journal *Archives of Internal Medicine*.

Shrank's group analyzed how well 6,755 patients enrolled in a three-tier pharmacy benefit structure stuck to their drug regimens. Under their benefit plan, the patients had to pay the highest co-payment for non-preferred brand-name drugs (third tier), smaller co-payments for preferred brand-name drugs (second tier), and smallest or no co-payment for generic drugs. The group received a total of 7,532 new prescriptions during the study period. There were six classes of drugs included in the study: cholesterol-lowering statins; oral contraceptives; orally inhaled corticosteroids (asthma); and three antihypertensives (calcium-channel blockers, angiotensin receptor blockers and angiotensin converting enzyme inhibitors). Patients who took generic drugs showed a 12.6 percent increase in therapy adherence, compared to patients who took brand-name third-tier drugs, the study found. Patients who took second-tier drugs had an 8 percent increase in adherence compared to those who used third-tier drugs.

Other findings:

- Patients who took a generic drug had a 62 percent better chance of achieving adequate adherence and those who took a brand-name second-tier drug had a 30 percent better chance than those who took third-tier drugs.
- Patients who were initially prescribed third-tier brand-name drugs were 2.1 times more likely to switch to a drug in another tier than patients initially prescribed generic drugs.
- Patients who switched from their initial prescription were 2.8 times more likely to switch to a less-expensive, lower-tier brand-name or generic than to a higher-tier drug.
- Patients who initially received generic drugs switched at less than half the rate of those who received third-tier drugs.

"Physicians commonly prescribe chronic medications for important medical problems. Both physicians and patients should be aware of how the medication choice directly influences the patient's ability to follow the prescribed treatment," Shrank said.

Attention Providers Updated Information NICU PEDS Tool Program

Since you last heard from us, there have been some minor changes in order to be reimbursed for developmental screening. The following requirement apply:

- Completion of the PEDS training program
- Copy of your certificate must be on file with CMDP (this should be submitted to the attention of Provider Services)
- Prior Authorization is required
- At-risk infants discharged from the NICU are eligible for the PEDS developmental screening program; and copies of the PEDS tool is required to be submitted with the CMS 1500 form
- When billing CPT 96110 it must be billed using modifier "EP"
- Reimbursement for 96110 is $29.60
- 96111 is no longer part of the NICU PEDS Tool Program

For information regarding training please contact, the AzAAP through their web-site www.azaap.org or by calling (602) 532-0137. Or feel free to contract your Provider Service Representative at (602) 351-2245.

National Provider Identifier (NPI)

Effective January 23, 2004 the final rule regarding the National provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May. AHCCCS and CMDP will require the NPI to be used as the healthcare provider identifier in all claim submissions starting in May 2007.

Providers currently registered with AHCCCS are encouraged to submit their NPI number to AHCCCS Provider Registration. To submit the NPI number, providers can mail or fax a copy of their NPI notification email to:

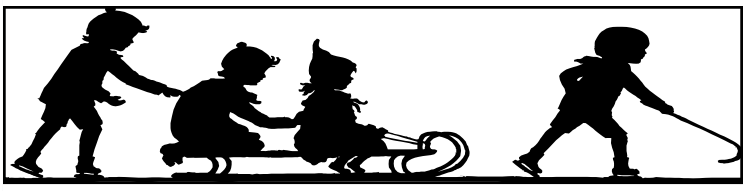
AHCCCS Provider Registration Unit
P.O. Box 25520 Mail Drop 8100
Phoenix, Arizona 85002
Fax: (602) 256-1474

When submitting this information the documentation must include the provider's name and AHCCCS ID number. The NPI number will also be accepted via written notification. Notification must include the provider's name, AHCCCS ID number and signature of the provider or authorized signor. AHCCCS is targeting January 1, 2007 as the optional claims and encounter submission date. Effective May 23, 2007 all claims and encounters must be submitted with the NPI when applicable.

Providers may obtain additional information about the NPI at www.cms.hhs.gov/hipaa/hipaa2. This site contains frequently asked questions and other information related to NPI and HIPAA standards. Should you have any questions regarding this information contact your Provider Service Representative at CMDP (602) 351-2245 for assistance.

Cultural Competence

The Goal: is to not let your own cultural values and beliefs interfere with providing quality health care. The difference between a provider who is culturally competent and one who is culturally aware is in the service that is provided. A culturally competent provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.



CMDP Eligibility Verification

CMDP offers our providers eligibility verification via e-mail. We would also encourage you to contact us at least one day prior to the member's appointment whether requesting verification by telephone or by e-mail. This will enable CMDP to resolve any eligibility issues prior to the member's appointment.

MariaVillanueva@azdes.gov

Lmoore@azdes.gov

Vguzman@azdes.gov

(602) 351-2245 / (800) 201-1795

Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP)

The report summarizes recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) concerning influenza vaccination of health-care personnel (HCP) in the United States. These recommendations apply to HCP in acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, and outpatient clinics and to persons who provide home health care and emergency medical services.
The recommendations are targeted at health-care facility administrators, infection-control professionals and occupational health professionals responsible for influenza vaccination programs and influenza infection-control programs in their institutions. HICPAC and ACIP recommend that all HCP be vaccinated annually against influenza. Facilities that employ HCP are strongly encouraged to provide vaccine to their staff by using evidence-based approaches that maximize vaccination rates.

The recommendations were drafted after review of peer-reviewed scientific articles, and whenever possible are based on well-designed studies; certain recommendations
are based on strong theoretic rationale and expert opinion. All recommendations have been approved by HICPAC and ACIP. The committees involved in drafting and
reviewing these recommendations included persons with expertise in infectious diseases, infection control, pediatrics, vaccinology, internal medicine and public health. The recommendations are as follows:

- Educate HCP regarding the benefits of influenza vaccination and the potential health consequences of influenza illness for themselves and their patients, the epidemiology and modes of transmission, diagnosis, treatment and nonvaccine infection control strategies in accordance with their level of responsibility in preventing health-care–associated influenza.

- Offer influenza vaccine annually to all eligible HCP to protect staff, patients and family members and to decrease HCP absenteeism. Use of either available vaccine (inactivated and live, attenuated influenza vaccine [LAIV]) is recommended for eligible persons. During periods when inactivated vaccine is in short supply, use of LAIV is especially encouraged when feasible for eligible HCP. Provide influenza vaccination to HCP at the work site and at no cost as one component of employee health programs.

- Use strategies that have been demonstrated to increase influenza vaccine acceptance including vaccination clinics, mobile carts, vaccination access during all work shifts and modeling and support by institutional leaders.

- Use the level of HCP influenza vaccination coverage as one measure of a patient safety quality program.

Research Explores Prevalence, Cost and Treatment of Obesity among Children and Adolescents

Childhood Obesity: Costs, Treatment Patterns, Disparities in Care and Prevalent Medical Conditions presents key findings from an analysis of data on the prevalence, cost and treatment of obesity among children covered by Medicaid compared to those covered by private health insurance. The brief, produced by Thomson Medstat, examines data from 2004 for a subset of children and adolescents (ages 17 and under) who were treated at least once for a diagnosis of obesity as captured by medical claims from a national database of individuals with private health insurance and a database of individuals in eight states with Medicaid coverage. Disparities in the rates of children and adolescents diagnosed as obese, cost of care and treatment patterns are discussed. A chart comparing co-morbid medical conditions in children and adolescents with and without obesity is also presented. The brief is available at http://www.medstat.com/pdfs/childhood_obesity.pdf.

Updated Warnings for Eczema Medications

The Food and Drug Administration has approved updated labeling for two topical eczema drugs, Elidel Cream (pimecrolimus) and Protopic Ointment (tacrolimus). The labeling will be updated with a boxed warning about a possible risk of cancer. A Medication Guide will be distributed to help ensure that patients using these prescription medicines are aware of this concern.

FLU Shots Recommended for More Kids

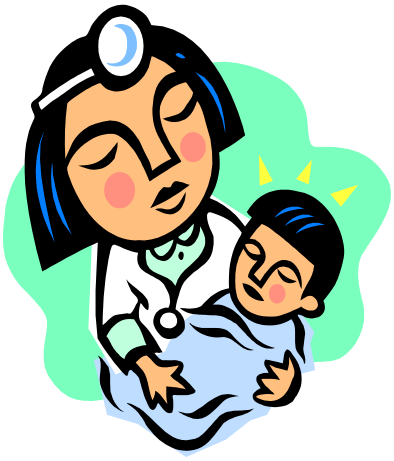
The Advisory Committee on Immunization Practices (ACIP) recommended to expand the standard recommendation for flu shots from the old 6-23 months age to all kids from 6 months to 5 years old. Once this recommendation is approved by the CDC it will greatly expand the number of kids that get the influenza vaccine in Arizona through our Vaccines for Children program http://www.azdhs.gov/phs/immun/act_aipo.htm.

Vaccinating kids is important for overall influenza disease control because kids are the "amplifiers" of influenza in a population. While vaccinating the elderly can be an effective way of saving their individual life, vaccinating one kid is like vaccinating lots of people because they are the ones that are the petri-dishes of the community.

Newborns and Hepatitis B

The Centers for Disease Control and Prevention have issued a letter intended for healthcare and public health professionals who provide care to pregnant women and infants. The following is an excerpt from the letter:

We would like to bring to your attention revised immunization recommendations from the Advisory Committee on Immunization Practices (ACIP) to ensure that newborn infants are protected from hepatitis B virus (HBV) infection, a major cause of cirrhosis and liver cancer in the United States. The ACIP now recommends that, except on a case-by-case basis and only in rare circumstances, universal infant hepatitis B vaccination should begin at birth. Previously, the ACIP noted a preference for giving the first dose at birth, but also recommended that infants born to uninfected mothers could receive the first dose at age 1-2 months. To prevent HBV transmission among children at greatest risk for HBV infection, the ACIP also recommends that prenatal care providers, delivery hospitals and health departments implement policies and procedures to identify and manage children born to infected mothers and mothers with unknown HBV infection status. The ACIP statement, including all of the revised recommendations, is available from CDC in the Morbidity and Mortality Weekly Report (http://www.cdc.gov/mmwr/PDF/rr/rr5416.pdf).



Recommendations for Prenatal Care Providers in the management of all pregnant women:

- Test all pregnant women for hepatitis B surface antigen (HBsAg) during each pregnancy.
- Transfer a copy of the original laboratory report of the pregnant woman's HBsAg test result to the patient's medical record in the delivery hospital.
- Inform pregnant women of the importance of newborn hepatitis B vaccination.
- Vaccinate pregnant women who are at risk for HBV infection.

Management of pregnant women with chronic HBV infection:

- Inform HBsAg-positive women of HBV transmission risks and ways to prevent HBV infection, including the importance of postexposure prophylaxis for newborn infants and hepatitis B vaccination of household, sexual and needle-sharing contacts.
- Refer HBsAg-positive women to an appropriate case-management program to ensure that their newborn infants receive timely postexposure prophylaxis and follow-up.

ADHD panel calls for added risk information, but no black box

A Food and Drug Administration Pediatric Advisory Committee has rejected having 'black box' warnings regarding psychiatric and cardiovascular risks associated with ADHD drugs. This advice goes against a recommendation issued one month ago by the Drug Safety And Risk Management Advisory Committee, which supported the idea of a black box warning.

Many in the medical profession, especially psychiatrists, have been expressing their concerns about the disadvantages of including stronger warnings, saying warnings could do more harm than good. The dangers of leaving many patients untreated may be much greater than the present risks these drugs present.

Stimulants like Ritalin lead a small number of children to suffer hallucinations and a panel of experts said on that physicians and parents needed to be warned of the risk. The panel members said they hoped the warning would prevent physicians from prescribing a second drug to treat the hallucinations caused by the stimulants, which one expert estimated affect 2 to 5 of every 100 children taking them. Instead, they said, the right thing to do in such cases was to stop prescribing the stimulants.

On Feb. 9, a different advisory committee voted 8 to 7 to recommend that the Food and Drug Administration place its most serious warning label, a so-called black box, on the labels of stimulants to warn that they could have dangerous effects on the heart, particularly in adults. That recommendation grew out of reports that 25 people, mostly children, had died suddenly while taking the drugs. The drugs (Ritalin, Adderall, and Concerta) have been studied in hundreds of trials over five decades and have proven to be extremely effective. Their use has always been controversial, with some experts saying that ADHD medications are over prescribed. F.D.A. officials made clear to the advisory panel that they considered the reports of hallucinations a problem that deserved a label warning.

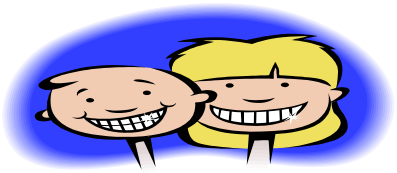
Updated Pediatric Immunization Schedule for 2006

Changes are:

* Hepatitis A vaccine is now recommended for universal administration to all infants 12 to 23 months of age, with a second dose six months later.

* A single dose of meningococcal conjugate vaccine, a vaccine to prevent sepsis and meningitis, is recommended for all 11-to 12-year-olds, for adolescents at high school entry or 15 years of age and for college freshmen who will be living in a dormitory.

* A single dose of an adolescent preparation of tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine is recommended for 11- to 12-year-olds, provided they have not received a tetanus and diphtheria (Td) booster dose, and for adolescents 13 to 18 years of age who missed the 11- to 12-year-old Td or Tdap booster dose.



CMDP Contacts:
(602) 351-2245 (800) 201-1795

MEMBER SERVICES:

Veronica Guzman...ext 7078
Linda Moore.....ext 7080
Maria Villanueva.....ext 7083

We are available to verify a member's eligibility. Please call with their name, date of birth, date of service & ID #.

PROVIDER SERVICES:

Cathy Nunez.....ext 7042
Mirtha Moreno.....ext 7110
Robert Casillas.....ext 7112

For all your concerns, Provider Serviices will assist you or direct you to the appropriate department.

CLAIMS:

For verification of claim status, please ask the operator for a claims representative.

MEDICAL SERVICES:

Susan Stephens, M.D., Medical Director.....ext 7065
Mary Ferrero, R.N., Medical Services Manager.....ext 7070
Hospitalizations.....ext 7116
EPSDT.....ext 7063
Prior Authorizations .....ext 7065
Behavioral Health.....ext 7009 / 7060
Social Services.....ext 7073

Please contact Medical Services with any questions regarding the medical needs of our members.